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continuous services to recipients as required under the county's invitation for bid, prior to making a contract award. Nothing however, precludes a requirement that contracts under this section be awarded on a competitive bid basis.

(3) The reimbursement rates shall not exceed the State's maximum authorized hourly In-Home Supportive Services program rates for the contract mode of service.

(4) Reimbursement rates established through a contract between a county and a contract provider in compliance with this paragraph E constitute rates recommended by the Department for purposes of paragraph D(2), above.

F. RATE METHODOLOGY FOR SERVICES PROVIDED BY A PUBLIC AUTHORITY OR BY A NONPROFIT CONSORTIUM

(1) A county board of supervisors may, at its option, elect to do either of the following:

(a) Contract with a nonprofit consortium to provide for the delivery of personal care services.

(b) Establish a public authority to provide for the delivery of personal care services.

(2) Any nonprofit consortium contracting with a county pursuant to this section or any public authority will provide for the functions specified in California Welfare and Institutions Code section 12301.6, subdivision (d), including, but not limited to, performing functions related to the delivery of personal care services, and ensuring that the requirements of the personal care

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option pursuant to Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are met.

(3) Within the meaning of Chapter 10 (commencing with Section 3500) of Division 4 of Title 1 of the California Government Code relating to collective bargaining by employee organizations that include employees of a public agency, any public authority created pursuant to this section is deemed to be the employer of persons referred to recipients to provide personal care services and is also deemed to be the Medi-Cal provider of record.

(4) Any nonprofit consortium contracting with a county pursuant to this section is deemed to be the employer of personal care services personnel referred to recipients for the purposes of collective bargaining over wages, hours, and other terms and conditions of employment and is deemed to be the Medi-Cal provider of record.

(5) To the extent permitted by federal law, personal care option funds, obtained pursuant to Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code, along with matching funds using the state and county sharing ratio established in California law or any other funds that are obtained pursuant to Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code, may be used to establish and operate an entity authorized by this section.

(6) The county, in exercising its option to establish a public authority, shall not be subject to competitive bidding requirements. However, contracts entered into by either the county, a public authority, or a nonprofit

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consortium pursuant to this section shall be subject to competitive bidding as otherwise required by law.

(7) Recipients shall retain the right to select, terminate, and direct the work of any person providing personal care services to them.

(8) The Department will not reimburse a public authority or consortium for personal care services at more than 200 percent of California's hourly minimum wage (on a per unit of service basis).

(9) Payment rates established by a public authority or a nonprofit consortium in compliance with this paragraph F constitute rates recommended by the Department for purposes of paragraph D(2), above.

G. SCHEDULE OF MAXIMUM ALLOWANCE (SMA) RECOMMENDED RATES

(1) Based upon the SMA rate analysis performed pursuant to paragraph H, the Department will recommend SMA rates (as referenced in paragraph D(2), above) for reimbursement of individual providers of personal care services which may be statewide, or vary by county or other geographic area.

(2) Statewide, county, or other geographic area individual provider SMA recommended rates adopted pursuant to paragraph H, will not exceed prevailing wages including statutorily mandated employer contributions for benefit costs (i.e., Social Security, etc.) for like services on a statewide average or applicable geographic area average basis, respectively. If county or other geographic area rates are adopted, no such geographic rate shall exceed 115 percent of the statewide average of prevailing wages

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in each county, as determined by the Employment Development Department (including employer benefit contributions) for like work.

(3) Any wages negotiated or paid by any public or private employer for Personal Care Services that are found by the Department to be substantially in excess of prevailing wages for job skills, ability, education or experience similar to those in the personal care industry shall be deemed excessive and not recognized in determining the SMA rates.

(4) The individual provider SMA recommended rates shall not exceed 150 percent of California's hourly minimum wage.

(5) The SMA rates shall not exceed Medicare maximum allowances for similar services, and shall conform to all applicable state and federal laws and regulations governing provider reimbursement rates.

H. SMA RATE METHODOLOGY FOR INDIVIDUAL PROVIDERS

(1) The SMA recommended rates for individual providers will be determined based on an analysis of appropriate economic factors, on a geographic or statewide basis within the State of California. The primary objectives of the analysis will be (a) identification of rates sufficient to ensure adequate access to Personal Care Services, and (b) that the rates are consistent with efficiency, economy and quality of care.

(2) Analysis of economic factors may include evaluation of wages for services comparable to Personal Care Services, on a geographic basis. Available county and/or state data may be analyzed to first determine if and where

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logical geographic groupings occur. This may include cities, counties, and/or regions, depending upon the analysis results.

(3) Analysis of available claims data, combined with eligibility information, will provide the basis for an access study. This may be conducted over a period of time, depending on data availability, quality and consistency. Other available data from the paid claims system or other sources may be analyzed, as appropriate.

(4) The SMA recommended rates will be calculated, based on the results of the analysis of economic and other relevant factors, on a statewide, county, or other geographic area basis. Calculations may include a form of averaging, or identifying the mean of specific geographically comparable wages, or other factors. Other analyses may be undertaken to evaluate program effectiveness and adequacy of access. Such analyses may include, but not necessarily be limited to:

- o Geographic area analysis of expenditures per Medi-Cal recipient.
- o Geographic area analysis of average and total hours per Medi-Cal recipient.
- o Comparison of utilization to eligibility factors.

(5) Prior to commencing the rate study pursuant to this section, the department will make public a notification of its intent to commence the rate study. Counties may submit to the Department data regarding the county's individual economic conditions, prevailing wages for like services, access information, or any other information that the county finds relevant to the rate study.

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(6) SMA rates will be reviewed periodically, to ensure that access is not impaired. These reviews may include an analysis of inflation indicators, regional or statewide wage studies, or other appropriate data. Any county or group of counties may at any time request a periodic rate review, irrespective of any regularly scheduled periodic review, if the county or group of counties believe that conditions which bear on the results of the rate study have changed subsequent to the previous periodic review. The Department will consider such requests, and, based on the information presented in the request, may undertake a periodic rate review.

I. PAYMENTS AND UNITS OF SERVICE

Reimbursements for services shall be made only to the provider authorized by the Department to provide Personal Care Services to beneficiaries. The rates shall be based upon a time-based unit of service.

J. PUBLIC HEARING

(1) The evidentiary database used to develop the rates will be made publicly available and a public hearing convened pursuant to paragraph (b) at page 1 of this Attachment 4.19-B. Interested parties, including beneficiaries, counties, public authorities, nonprofit consortia, unions representing providers of personal care services, and the general public will have the opportunity at the public hearing to request adjustment of rates and may present any relevant testimony, including, but not limited to, any of the matters specified in Welfare and Institutions Code Section 14132.95, subdivision (j)(2).

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(2) Rates adopted in the California Code of Regulations will reflect the total rate, inclusive of any county participation in the state share pursuant to paragraph D(2), above.

State/Territory: California

Citation | Condition or Requirement

REIMBURSEMENT FOR DRUG MEDI-CAL SERVICES

The policy of the State Agency is that reimbursement for Drug Medi-Cal services shall be limited to the lowest of published charges, Statewide Maximum Allowances (SMAs), or actual cost of rendering the service as determined by annual cost reports submitted by the providers. In no case shall payments exceed SMAs. For Narcotic Replacement Therapy, reimbursement is limited to the lower of the provider's usual and customary charges for the same or similar service or the fixed rate.

A. DEFINITIONS

"Published charges" are usual and customary charges prevalent in the alcohol and drug treatment services sector that are used to bill the general public, insurers, and other non-Title XIX payers. (42 CFR 447.271 and 405.503(a)).

"Statewide maximum allowances" are upper limit rates, established for each type of service, for a unit of service. Units of service means a face-to-face contact on a calendar day for Outpatient Drug Free, Day Care Rehabilitative, Perinatal Residential, and Naltrexone treatment services. For Narcotic Treatment Program services, "Unit of Service" means each calendar day a client receives services, including take-home dosing.

"Actual cost" is reasonable and allowable cost, based on year-end cost reports and Medicare principles of reimbursement as described at 42 CFR Part 413 and in HCFA Publication 15-1.

"Provider of Services" means any private or public agency that provides direct substance abuse treatment services and is certified by the State as meeting applicable standards for participation in the Drug Medi-Cal program, as defined in the Drug Medi-Cal Certification Standards for Substance Abuse Clinics.

State/Territory: California

Citation	Condition or Requirement

"Unit of service" means a face-to-face contact on a calendar day for Outpatient Drug Free, Day Care Rehabilitative, Perinatal Residential, and Naltrexone treatment services. For these services, only one unit of service per day is covered by Drug Medi-Cal except for emergencies when additional face-to-face contact may be covered for unplanned crisis intervention. To count as a unit of service, the second contact shall not duplicate the services provided on the first contact, and the contact shall clearly be documented in the beneficiary's patient record. For Narcotic Treatment Program services, "Unit of Service" means each month a client receives services, including take-home dosing.

"Legal entity" means each county alcohol and drug department or agency and each of the corporations, sole proprietors, partnerships, agencies, or individual practitioners providing alcohol and drug treatment services under contract with the county alcohol and drug department or agency or with the State Department of Alcohol and Drug Programs (ADP).

B. REIMBURSEMENT METHODOLOGY

1. The reimbursement methodology for providers of Drug Medi-Cal Outpatient Drug Free, Day Care Rehabilitative, Perinatal Residential and Naltrexone treatment services, is based on the lowest of:

   a. The provider's published or customary charge to the general public for the same or similar service,

   b. The provider's allowable costs; or

   c. The SMAs established as defined in Section C, below, by ADP and approved by DHS.

State/Territory: California

Citation | Condition or Requirement

The above reimbursement limits are applied at the time of settlement of the year-end cost reports. Reimbursement is based on comparisons to each provider's total, aggregated allowable costs after application of SMAs to total aggregated published charges, by legal entity.

2. The reimbursement methodology for providers of Drug Medi-Cal Narcotic Treatment Program services, is based on the lowest of:

   a. The provider's published or customary charge to the general public for the same or similar service, or

   b. The statewide rates established by ADP and approved by DHS as defined in Section D.

C. SMA METHODOLOGY FOR OUTPATIENT DRUG FREE, DAY CARE REHABILITATIVE, NALTREXONE TREATMENT, AND PERINATAL RESIDENTIAL SERVICES

The SMAs are based on the statewide median cost of each type of service as reported in the year-end cost reports submitted by providers for the fiscal year which is two years preceding the year for which SMAs are published.

D. STATEWIDE FIXED RATE METHODOLOGY FOR NARCOTIC TREATMENT PROGRAMS

The statewide fixed rate is based on the averaged daily cost of dosing and ingredients and ancillary services, based on the annual cost per patient and a 365-day year, using the most recent and accurate data available, and in consultation with DHS, narcotic treatment providers and county alcohol and drug program administrators.